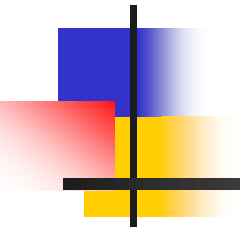


# MOOD DISORDERS IN THE ELDERLY



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# OUTLINE OF PRESENTATION

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- Introduction
- Epidemiology (Incidence and Prevalence)
- Etiology
- Diagnostic Work Up
- Clinical Presentation
- Diagnosis and Differential Diagnosis
- Suicide
- Treatment





# STATISTICS

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- 1980 - 10% > 65 = 25 Million
- 1900 - 3% > 65 = 3 Million
- 1992 - 12% > 65 = 30 Million
- Fastest Growing Cohort in our Society: > 85
- > 100 ( Willard Scott's Group) = 32,000
- 2020 - More > 65 than < 18
- 2080 - MORE THAN ONE MILLION > 100





# MOOD DISORDERS ARE:

Common in the Elderly

- Significant cause of Morbidity and Mortality
- Tend to be more persistent than in younger patients
- “Failure to Thrive” syndrome
- Linked to increased Physical Pain in Patients with Medical Problems (especially Arthritis & Cancer)
- Depressed Elderly Increased Risk of Mortality from Medical Illness as Compared with Age Matched Controls



# DEPRESSION IN THE ELDERLY IS A MAJOR PUBLIC HEALTH PROBLEM

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Many go undiagnosed

- Diagnosis is challenging in context of Multiple Physical Problems
- Feeling in both Patients and Caregivers/Health Personnel that Depression is a normal consequence of all the Physical, Social and Economic Problems of the Elderly



# THREE QUESTIONS TO ADDRESS

- How does Depression in Late Life differ from Depression earlier in life? What are the sources of heterogeneity within Late Life Depression?
- How prevalent is Depression in the Elderly and What are its Risk Factors?
- What constitutes Safe and Effective Treatment for Late Life Depression? What are the Indications and Contraindications for Specific Treatments?





# DEPRESSION

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“Depression is a Syndrome which includes a Constellation of Physiological, Affective and Cognitive Manifestations.”



# SIGNS & SYMPTOMS ACCORDING TO THE DSM IV ARE:

- Changes in Appetite
- Disturbed Sleep
- Motor Agitation or Retardation
- Fatigue and Loss of Energy
- Depressed or Irritable Mood
- Loss of Interest or Pleasure in Usual Activities
- Feelings of Worthlessness, Self-Reproach, Excessive Guilt
- Suicidal Thinking or Attempts
- Poor Concentration







# IN THE ELDERLY

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- Clinicians and patients attribute (incorrectly) depressive symptoms to the aging process
- Expectations of lower level of functioning in the post-retirement years
- Symptoms may differ, the elderly may readily report somatic symptoms i.e. chronic pains, gastrointestinal distress, etc. rather than depressed mood
- More attention paid to the physical problems by clinicians - Depression is overlooked



# DEPRESSION FREQUENTLY COEXISTS WITH MULTIPLE CHRONIC DISEASES & DISABILITIES

- Cancer, cardiovascular disease, neurological disorders, various metabolic disturbances, arthritis, and sensory loss. All these can directly contribute to the cause of depression and can complicate treatment.
- Advancing age is accompanied by loss of important social support systems due to death of spouse, siblings, friends, retirement, or relocation.



# SOURCES OF HETEROGENEITY

- Biologically there is usually a slowing of the :
  - Organ Systems
  - Decrease in Immunologic Responsiveness
  - Change in Body Composition
- Leading to major implications for risk of illness, diagnosis, and treatment.
- Antidepressants levels can be disproportionately high making the aged particularly vulnerable to adverse side effects.



# LATE ONSET DEPRESSION IS ASSOCIATED WITH:

- A lower frequency of the family history of depression
- A higher frequency of cognitive impairment, cerebral atrophy, recurrences and medical comorbidity, and mortality





# EPIDEMIOLOGY

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- According to the Epidemiologic Catchment Area Study (EPA), Depressive Symptoms occur in approximately 15% of community residents over 65 years of age.
- Prevalence of Depression in the elderly living in the community is estimated at 2 to 3%. The rate of Depression in Primary Care Clinics is 15%, in Nursing Homes 25 to 30%.
- New episodes of Depression in a 1-year period in Nursing Homes is 13%, and another 18% Develop New Depressive Symptoms.





# RISK FACTORS FOR DEPRESSION

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- Social and demographic
  - Women
  - Unmarried/Widowed
  - Stressful Life Events
  - Lack of Supportive Social Network
- Physical Conditions
  - Stroke
  - Cancer
  - Dementia-Pseudodementia (Dementia Syndrome of Depression)



# RISK FACTORS FOR DEPRESSION

## (con't)

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- Depression in medically ill patients enhances vulnerability of the immune system
- Some medications commonly used can cause depression
  - Beta Blockers e.g. Inderal
  - Anti Glaucoma medication e.g. Betaxolol & Timolol
  - Pain Medication e.g. Narcotics





# DIAGNOSIS

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- No specific diagnostic lab test can be recommended at this time. Therefore, an Attentive and Focused Clinical Interview remains the mainstay for the evaluation and diagnosis of depression.
- Depression assessment scales for clinical use
  - Geriatric Depression Scale







# SUICIDE IN THE ELDERLY

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- Over 6,000 elderly persons die each year of Suicide
- Elderly persons represent only 12% of the US population but account for 20% of Suicides.





# SUICIDE IN THE ELDERLY

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- Many older individuals who completed their Suicide had Diagnosable Mental Illness(Carlson, 1984)
- Depression is the most common mental illness for those who have Attempted Suicide (Lyness, Conwell, and Nelson, 1992)
- Biologic factors related to Suicide include reduced levels of Serotonin (Asberg et al., 1976; Prung, 1982)





## FACTORS ASSOCIATED WITH RISK FOR SUICIDE IN THE ELDERLY INCLUDE:

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- HIGH SOCIOECONOMIC STATUS
- PAST SUICIDE ATTEMPTS
- MORE PERSISTENT INDEX  
EPISODES OF DEPRESSION

(Maahan, Salzman, Sattin, 1991)





## SUICIDE IN THE ELDERLY:

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- More than 80% of elderly individuals who committed suicide had visited their primary care physician within a month of their death and 29% had done so within 24 hours.

(AARP, 1993)



# TREATMENT OF DEPRESSION IN THE ELDERLY

## ■ GOALS OF TREATMENT

- Decreasing Symptoms of Depression
- Reducing Risk of Relapse and Recurrence
- Increasing Quality of Life
- Improving Medical Health Status
- Decreasing Health Care Costs and Mortality





# TREATMENT (con't)

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- Two major categories of treatment are:
  - Biological (Pharmacotherapy & ECT)
  - Psychosocial Therapy





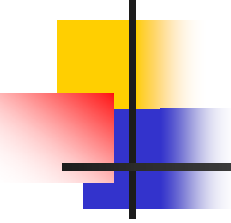
# TREATMENT (con't)

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- ANTIDEPRESSANTS - TYPICALS  
TRICYCLICS
  - Most commonly used and studied
  - Desipramine, Nortriptyline
  - Avoid Amitriptyline and Imipramine



# DIFFERENTIAL SIDE EFFECTS OF TRICYCLIC ANTIDEPRESSANTS IN THE ELDERLY



Drug class	Sedation	Orthostasis	Anticholinergic Effects
<ul style="list-style-type: none"> <li>■ <u>Tertiary Amines</u></li> <li>■ (Imipramine,</li> <li>■ Amitriptytine,</li> <li>■ Doxepin</li> </ul>	Strong	Strong	Strong
<u>Secondary Amines</u> <ul style="list-style-type: none"> <li>■ _Desipramine</li> <li>■ Nortriptyine</li> <li>■ Protriptyine</li> </ul>	Activating Moderate Activating	Moderate Weaker Moderate	Weaker Moderate Moderate





# TREATMENT OF DEPRESSION

## (con't)

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### Antidepressants (con't)

- Selective Serotonergic Reuptake Inhibitors (SSRI's)
  - Fluoxetine (Prozac)
  - Sertraline (Zoloft)
  - Paroxetine (Paxil)
  - Fluvoxamine (Luvox)
  - Citalopram (Celexa)
  - Escitalopram (Lexapro)





# SSRI THERAPY OF DEPRESSION

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- As effective as TCAs:
  - Doxepin vs Paroxetine or Fluoxetine
  - Amitriptyline vs Paroxetine, Fluoxetine, or Sertraline
- Minimal Anticholinergic Effects
- No Orthostasis
- Agents with long half-lives may accumulate in elderly and prolong side effects





# SSRI'S AND THE ELDERLY:

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- "A major advantage of these agents (Sertraline {Zoloft} and Fluoxetine {Prozac}) over other antidepressants is that they may be less lethal when taken in overdose; this is of particular concern in the elderly, considering their increased risk for suicide."

Yrsavage, Postgraduate Medicine, 1992.





# TREATMENT (Con't)

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- Other Antidepressants
  - Bupropion (Wellbutrin)
  - Venlafaxine (Effexor)
  - Nefazadone (Serzone)
  - Trazadone (Desyrel)
  - Remeron





# TREATMENT (con't)

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- Response depends on:
  - Adequate length of treatment (6 - 12 weeks)
  - Dose and Blood Levels
  - Compliance - 70% of patients fail to take 25% to 50% of their medication. Non-compliance predicts poor outcome.





# ELECTRO CONVULSIVE THERAPY (ECT)

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- ECT has an Important Role in Treatment of Depression in the Elderly
- A National Institute of Mental Health (NIMH) study shows patients over 61 constitute the largest age group who receive ECT.
- Efficacy for short-term response is strong. Relapses are frequent.
- Maintenance ECT and maintenance antidepressants post-ECT helps.





# PSYCHOSOCIAL TREATMENTS

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- Psychosocial treatments have very few studies on efficacy
  - Cognitive therapy
  - Behavior therapy
  - Interpersonal therapy
  - Short-term psychodynamic therapy
  - Social support and treatment of family caregivers



# PSYCHOSOCIAL TREATMENTS

## (con't)

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- Special approaches to treatment for the elderly with physical illnesses and disabilities
  - Visual & hearing impairment
  - Cognitive impairment
- Senior centers with therapeutic recreational activities, nutritional programs and volunteer services, etc.





# TREATMENT OF SECONDARY DEPRESSION

- Concurrent medical illnesses
  - To be treated as virgorously as primary depression
- Self-help groups for approximately 800,000 persons widowed each year
- If untreated secondary depression can lead to Major Depression **and Suicide**





# SUMMARY AND CONCLUSIONS

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- Depression is common in the elderly, but often underdiagnosed and undertreated
- Accurate diagnosis is important to determine cause of depression
- Depression in elderly should be vigorously treated
- Consider full-dose maintenance therapy





# SUMMARY AND CONCLUSIONS

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- Selective serotonin reuptake inhibitors are effective and preferred in elderly
- Desipramine and nortriptyline should be prescribed cautiously
- Trazodone, bupropion, MAOIs, ECT may be useful alternatives

